

CLINICAL CHARACTERISTICS OF OLDER PSYCHIATRIC INPATIENTS WITH BORDERLINE PERSONALITY DISORDER

Brian Trappler, M.D., and Jill Backfield, Ph.D.

This case study investigation considers typical and potentially unique characteristics of older (> 50 years) Borderline Personality Disorder (BPD) patients and describes their impact on an inpatient psychiatric unit encompassing a therapeutic milieu setting and multidisciplinary treatment teams. The somatization of symptoms, in particular, and the associated therapeutic, medical, and psychopharmacological interventions, result in prolonged and elaborate treatments that undermine clinical and personal boundaries, clash with managed care directives, and engender frustrating and elusive transference and countertransference reactions. Moreover, the guilt-inducing nature of somatization and physical frailty in older individuals, combined with the well-documented ability of BPD patients, regardless of age, to incite stormy and 'split' relationships, are linked characteristics that may describe a diagnostic subtype of BPD. Rather than suggesting a diminution of psychopathology as BPD patients age, the results of this investigation indicate that their persistent difficulties may only be altering in content and in pathological adaptation to changing needs.

KEY WORDS: Borderline Personality Disorder; older patients; inpatients.

Brian Trappler, M.D., is an Attending Psychiatrist and Assistant Clinical Professor of Psychiatry, State University of New York, Health Science Center at Brooklyn, NY.

Jill Backfield, Ph.D., is a Clinical Psychologist and Adjunct Associate Professor of Psychology, Teachers College, Columbia University, New York, NY; Director of Psychological and Clinical Consulting, P.C., NY; and was a Postdoctoral Clinical Psychology and Research Fellow and Clinical Instructor in the Inpatient Service and Psychology Unit, Department of Psychiatry, State University of New York, Health Science Center at Brooklyn from 1994 to 1997.

Address correspondence to Dr. Trappler at the Department of Psychiatry, State University of New York, Health Science Center at Brooklyn, Box 1203, 450 Clarkson Avenue, Brooklyn, NY 11203.

Although clinical qualities of Borderline Personality Disorder (BPD) in older patients (> 50 years) have been expressly scrutinized in the psychiatric literature for the past twelve years, an overall lack of knowledge remains about the manner in which the core diagnostic features persist in older patients. A comprehensive analysis by Stone (1) in 1992, evaluating 25 years of studies of BPD patients and distinctions among course of illness, outcome, and natural history, did not consider patients older than 45. In 1986, Siegel and Small remarked that they could find no report in the literature that clearly delineated a geriatric case of Borderline Personality Disorder fulfilling DSM-III criteria (2). In an ensuing study, Rosowsky and Gurian (3) suggest that the expression of symptoms in older patients no longer satisfy diagnostic criteria thresholds for BPD, using either Diagnostic Interview for Borderlines-Revised (4) or DSM classification systems (5). Although certain characteristics of BPD in older patients, such as spontaneous self-mutilation, suicidality, substance abuse, and aspects of identity disturbance all persist, comparative evaluations of patients with BPD have suggested that these characteristics become less apparent with age (2).

With respect to traditionally recognized BPD symptoms, Modestin (5) noted that distorted interpersonal relationships consistently distinguished this disorder from other psychiatric and personality disturbances in the elderly. He further suggested that the negative reactions of staff to BPD patients remained robust and pervasive over time. Nevertheless, because some features diminish as BPD patients grow older, Rosowsky and Gurian conclude that a core set of enduring clinical symptoms needs to be established in order to accurately recognize this syndrome in the aging patient (3).

Considerable theoretical and clinical attention has been paid to defining a discriminative domain of BPD characteristics manifest early in psychological development and persisting into old age. In this regard, Adler (6), Gunderson and Sabo (7), Kernberg (8), Meissner (9), Searles (10), Stone (1) and Zanarini (11) have suggested that the following attributes serve as distinguishing and abiding symptoms, irrespective of age: 1) the expression of ideational themes of abandonment, engulfment and annihilation, echoing developmental episodes of abuse and deprivation; 2) demonstrations of overt demandingness and rage, often accompanied by a pervasive sense of narcissistic entitlement; 3) regressive episodes involving transient psychosis and psychotic transferences and; 4) the commanding ability to engender negative and intense countertransference and counterproductive reactions in caregivers and others. However, although numerous empiri-

cal and qualitative studies have attempted to characterize the impact of older BPD patients on such support networks as case management environments (12), day treatment centers (13), family systems (14,15), and outpatient treatment providers (15,16), the specific impact of older BPD patients on inpatient treatment settings remains unexplored. This absence of information is also of particular economic concern, given the degree to which the aged are the fastest growing segment of the population and require ever-increasing amounts of care (2,3). Because of its focus on diagnostic clarity and its therapeutic community milieu treatment approach, our psychodynamically oriented psychiatric inpatient unit appeared to serve as a suitable treatment environment to study the diagnostic, developmental, and clinical characteristics in these older BPD patients.

METHOD

By relying on DSM-IV (17) and clinical parameters of BPD assumed to describe all BPD patients (1,8) irrespective of age, we evaluated the impact of three older BPD patients on the psychiatric milieu from admission to discharge. The average length of hospitalization on this unit is approximately three weeks. Although DSM-IV Axis II diagnosis for each patient was deferred at hospital admission, all three patients had been diagnosed as having BPD at discharge. While our patients all met the DSM-IV criteria for BPD, our diagnosis also relied on other established clinical criteria (1,8) for 'borderline' pathology. In addition, two patients also had Axis I diagnoses of atypical mood disorder and one had Bipolar II Disorder (Mixed).

The patients were selected for evaluation because they met study criteria for age (>50). Although much of the age-related literature describes older individuals as 'elderly' or 'geriatric' once they reach the age of 65, relevant psychiatric literature emphasizes that the characteristics of mental disorders can undergo significant changes at approximately age 50 (2,17). Furthermore, for BPD patients, given their extremely high mortality and suicide rate earlier in adulthood (1), attaining age 50 appears to mark a significant point in the course of illness. However, designating these patients as 'older' indicates the degree to which this issue remains empirically unclarified and where this study hopes to make some contribution.

The following case presentations describe the patients, their histories, and clinical characteristics and behavior during the course of hospitalization. Case documentation was provided by their primary ther-

apists and other professional staff during thrice weekly treatment team meetings. Once admitted, patients are oriented by the staff and patient community and are made aware of the teaching, training, and clinical research components of our unit. They are further informed that they, or material relevant to their case histories, will be discussed in team case conferences and also included in training and clinical research endeavors. In presenting the cases, identifying details are omitted to protect patients' privacy.

Case 1

A 53 year-old, overweight, widowed, and childless woman with no work history had experienced multiple prior psychiatric admissions beginning in her early 30's. She also reported a history of seizure disorder since childhood. Her admitting complaint was of having become "extremely worried and depressed" about her seizures. She had complained to her neurologist of an increasing frequency of seizures and had received increasing dosages of anticonvulsants, which caused her to become dizzy and nauseated. Furthermore, her mother had recently moved to another state to be closer to grandchildren born to the patient's brother.

At age 12, the patient experienced her first seizure episode, during the period when she, her parents, and her nine siblings were in the process of changing their religious affiliation. In spite of numerous neurological evaluations with negative or equivocal results, she had been treated with anticonvulsants for 40 years. The patient described herself, prior to the onset of her seizure disorder, as "always in a rage" and "very mean and nasty." She apparently bullied classmates and siblings, was particularly vulnerable and reactive to comments about her body and, with the slightest provocation, would engage in physical and verbal fights. After the family's religious conversion, however, she believed she and her family members had become "nice people" who no longer fought with each other. Because of her seizure disorder, she never attended school and was tutored at home until she graduated from high school. She recalled having no friends while growing up and living a "chaotic life" with so many sisters and brothers. She hinted that she may have been sexually abused by one of her brothers. Eventually she married a man 20 years her senior; he died of cancer five years later.

During her adult years, she was admitted to several psychiatric units with complaints of "depression, anxiety, and worry" regarding the failure of medication to control her seizures. She would try repeatedly to hurt herself by throwing herself on the ground. There was

a substantial history of polypharmacy, involving numerous types of neuroleptic and anticonvulsant medications. She was frequently referred for psychiatric evaluations by her neurologist and others who variously described her as “lonely, depressed, demanding, noncompliant, dependent, somatizing, attention-seeking, and a ‘regular’ at psychiatric emergency rooms.” In the past year, the patient had received three-times-per-week home attendant service, and had little regular contact with her family or others. On admission, she complained of depression, of preoccupation with being overweight, and of ruminations about having a seizure when under any stress.

In individual therapy and in groups, she described persistent feelings of being lonely, sad, and angry, all of which conflicted with the need to be “nice.” She was frequently argumentative and demanding, ignored other patients, and constantly complained to staff that “as an older person” she failed to get any attention from staff for her constipation and stomach problems. A GI consult and work up was negative. She frequently requested prn’s of anxiolytics. After receiving them, she would complain of being “drugged up.” She asserted that she had not received the special food she had requested for her weight loss and asked to consult with a dietician daily. She was evaluated for after-hour and weekend complaints from three to six times per week. Towards the end of her hospitalization, she refused to be discharged unless assured that her home attendant service would be increased, because she was “too old and sick” to care for herself. She attempted to mobilize staff with predictions that a seizure was imminent. Several times, she complained of seizure-like symptoms at the time of scheduled discharge.

The patient’s primary therapist and members of the treatment team, despite their doubts, felt compelled to evaluate each of the patient’s numerous complaints and delay her discharge several times. Most of the uncertainties expressed by the primary therapist and other team members related to guilt-inducing concerns over the patient’s age and her physical vulnerability. However, they also felt intermittently antagonistic, hostile, frustrated, and hampered in discussing this patient, reactions that mirrored the patient’s own interpersonal and intrapersonal characteristics. Hence, she managed to achieve a temporary reprieve for her feelings of emptiness by extending her hospitalization for many weeks.

Case 2

A 53-year-old man with a history of multiple psychiatric admissions who had recently married a woman 23 years his junior, whom he

expected to become his caretaker. Experiencing disappointment with her failure to comply, he became increasingly despondent and ruminated about committing suicide. His past history revealed that he had been raised in poverty, in an environment where there was constant fighting over food and clothing. He was brought up by his mother and grandmother and emigrated with his mother to the US when he was in his early twenties. His father was a relatively aloof figure and an alcoholic. Eventually, the patient held several clerical and managerial positions. He had three children out of wedlock and then married another woman with whom he had four more children. The patient believed that his wife had been "selfish and aggressive" and that had never cared for him. He abused alcohol for long periods of his adult life but stopped drinking about four years prior to admission. Twenty years previously, he had developed seizures, and five years later a meningioma, which was successfully resected. He was left without residual neurological deficits but was given Dilantin prophylactically.

On admission to the unit, he appeared sad and troubled. He expressed a preoccupation with somatic sensations and also spoke of anxiety-ridden ruminations about his new wife and her "selfishness." His affect was constricted, and he remained aloof, avoiding group activities. He complained about vague pains in his stomach and groin. Occasionally, he would lie down on the floor and refuse to move. In response, staff would rush to his aid with the assumption he was seizing, but no seizures were ever documented by EEG. He frequently made sexually provocative comments to female patients and demanded staff attention. He often refused psychotropic medication, including anticonvulsants, which remained at subtherapeutic levels. In individual sessions, he expressed concerns about family issues. He talked of his sense of abandonment, and of his impotence and rage about being an "aging and unwell" man with a "selfish and youthful wife." To the primary therapist and treatment team, the clinical picture appeared consistent with Bipolar II Disorder (Mixed) with BPD on Axis II. The overall treatment approach was to help the patient contain his acting-out and somatizing behaviors with mood stabilizers, appropriate limit setting, and individual and group verbal therapies.

Two weeks after admission, and following a community meeting where he had publicly criticized staff for failing to help him with his "stomach problems," he developed signs of an acute abdomen. A surgical consult and subsequent work up showed acute cholecystitis, requiring an emergency cholecystectomy. When he returned to our psychiatric unit, he intermittently and deliberately reopened his surgical

wound. He therefore required one-to-one nursing care and nearly daily surgical consultation. For the next month, the patient would complain of constant pain and discharge from the wound, with the surgical resident visiting daily to change the patient's dressing.

His acting-out behaviors were understood as expressions of the aggressivity and helplessness around his severe dependency needs, and maintaining and managing treatment boundaries and containing primitive affects and regressed self-destructive impulses appeared to be the central therapeutic goal. The treatment proved to be difficult, however, as he was able to 'split' the medical/surgical staff from psychiatric staff, and sought out attention from on-call staff not familiar with the case. In addition, he induced his sister, a nurse at an affiliated hospital, to act as his 'agent' by pressuring his surgeons for additional treatment. The self-doubt that occurred within the psychiatric staff after he required emergency surgery raised considerable feelings of guilt and ambivalence that continued throughout his extended hospitalization.

Case 3

A 70 year-old widowed woman who was admitted to this unit two days after a five-month psychiatric hospitalization elsewhere, during which she had been refractory to a series of antidepressant medications. She had consistently complained of memory loss and confusion, although neuropsychological testing results were normal. Her comprehensive discharge plan had included day treatment, a home attendant, and contact, as needed, with a mobile crisis unit. However, after spending the post-discharge weekend at her daughter's, the patient felt overcome by feelings of loneliness, confusion, and suicidality in anticipation of returning alone to her own apartment, and called EMS.

She was an only child, raised by her mother and grandmother. During adolescence, following the death of her grandmother, she was sent to boarding school. She did not see her mother for the next three years, remaining at school even during holidays and summer vacations. Eventually, intending to make a "surprise visit" to her mother, she arrived to find an empty apartment. Her mother had moved without notifying her, and she did not discover her mother's whereabouts until a year later.

Nevertheless, following high school graduation, she went on to earn a bachelor's degree in psychology, married, and worked at various secretarial jobs. When she was about 30, her husband was killed in a

motorcycle accident. Shortly thereafter, she gave birth to her daughter but a post-partum depression, with suicidal ideation, led her to her first psychiatric hospitalization. The hospitalization lasted for two years, during which time the patient's mother cared for her granddaughter, a pattern that was to continue whenever the patient required rehospitalization. The patient and her daughter established a contentious relationship, particularly as the daughter blamed her mother for a chaotic childhood and the daughter's subsequent substance abuse problems. For the past several years, following the losses of several friends, she had been almost continuously hospitalized for depression with expressions of suicidal intent. However, she had no history of actual suicide attempts or gestures.

On this admission, she complained of memory problems, unremitting depression, and the feeling that "something had run down inside." Her range of affect appeared intense but appropriate to situational contexts. Despite her complaints of poor memory, she would spontaneously recollect recent and earlier life events during therapy sessions. She expressed feelings of dread that something "bad" would happen to her if she were discharged without someone to care for her. Her daughter refused to participate in family therapy and rarely visited.

After several weeks of antidepressant medication and psychotherapy, she was given a discharge date. She regressed acutely, remaining in her nightgown all day, stating she felt "desperate" and that she wished she "could go to sleep and not wake up." When persuaded, she would come into group meetings, announce that she felt "ill, dizzy, and confused" and that she was being "abused and not properly cared for in the hospital," and then leave to lie down in her room. However, following the conclusion of formal meetings or activities, she would get out of bed, dress up (often in a fashionable wig), and play pool and cards with other patients.

The on-call physician proved to be a frequent visitor for the patient's weekend and after-hour "dizzy spells" and the dramatic demands for treatment which she would typically display in front of the nursing station. Although she was evaluated for her many somatic complaints, no cause was found. She discontinued antidepressant medication. Instead, she would have the oncall doctor summoned at irregular hours to prescribe anxiolytics, only to complain to day staff of feeling "drugged up," and of being unable to attend milieu programs. After the team decided to withhold all psychotropic medications, she complained to administration of being "neglected and abused."

The primary therapist felt guilt, helplessness, and frustration. He was surprised at his sense of feeling ambushed by her ability to engender negative and even angry reactions in himself and other staff. He was also unable to find a suitable referral for aftercare and had to prolong the patient's discharge. She avoided participating in her own discharge planning, refusing even to be screened at senior citizen homes or 'family type' residences. After an extended hospitalization, and only after her primary therapist left for his next rotation, did she agree to be discharged home, to be followed at a day treatment center and by a mobile crisis team. Then, on the day after discharge from this unit, she presented at another psychiatric facility where she was admitted because of suicidal threats.

DISCUSSION

These cases demonstrate several traditional diagnostic and clinical features of BPD which persist in older BPD patients. Consistent with attributes that have typically served as discriminative characteristics of BPD regardless of age, all three cases recapitulated developmental experiences of abandonment, deprivation, and abuse. All three appeared to regress in the face of actual or perceived object loss, responding first by seeking the sanctuary of the hospital and later by extending their institutional stay. In reviewing the natural history of BPD cases defined either by DSM or by Gunderson and Kernberg's 'borderline personality organization' criteria, Stone notes the persistent, dismal life trajectory for those patients with both strong genetic loadings for affective illness and chronic parental abuse histories (1).

All three of our patients suffered comorbid affective illness as well as severe parental mistreatment. Significantly, all three exemplify the extreme intolerance of "aloneness," perceived abandonment, and "emptiness" recently noted by Gunderson (18) as the essential clinical features of BPD, features rooted in the early failure of the BPD patient to feel cared for and soothed. Gunderson describes these early failures and disruptions as the clinical links to the desperate, impulsive, manipulative, self-damaging actions outlined in DSM-IV BPD criteria (17). Such failures and disruptions, in turn, lead to the emotionally intense, manipulative, and 'stormy' relationships formed with treatment caregivers and others. These relationship constituents develop in the service of the patient's desire to repair, replace, or avenge these earlier experiences. Treatment staff, for their part, are uniquely vulnerable for induction into the role of providing comfort and grati-

fication. Furthermore, as Stone (1) indicates, BPD patients in their 40's are particularly susceptible to regressing and becoming symptomatic when faced with the actual loss of an adult, sustaining relationship, as occurred in our cases. Such responses to loss, Stone asserts, may be strongly predictive of poor treatment outcome.

We propose that accumulated object loss and increasingly vulnerable physical status in the aging BPD patient affords a unique opportunity to invoke early developmental failures. Somatization, treatment- and attention-seeking behaviors, and intense dependencies on treatment staff may represent late-onset BPD expressions and symptom transformations in our older patients. (Chart reviews revealed that these characteristics, as a cluster of symptoms, were not evident during the earlier course of our patients' illnesses.) Furthermore, frailty, object loss, and fear of abandonment in older BPD patients may also find particular expression and reinforcement in institutional settings. Regression, in these settings, can lead to heightened somatization, cause protracted hospital stays, and confound the treatment team in specific ways.

Our patients appeared able to identify staff who were more nurturing and emotionally vulnerable, less limit setting, and more susceptible to being defensively 'split'. In this regard, it was notable how capable our patients were of inducing feelings in staff of being 'good' or 'bad' caretakers. These diverse countertransference reactions sometimes would 'split' staff against each other. In fact, the customary feelings of forced intimacy usually characteristic of the psychiatric inpatient milieu may have engendered a maladaptive 'dance' of interpersonal rejections and affective intensities that Kernberg (8), Gabbard (19), and Stone (1) suggest characterize all therapeutic relationships for BPD patients. When these patients feel vulnerable, they become manipulative and demanding as a way of effecting a measure of control over the assumption they will be abandoned. Paradoxically, this inspires the recipients of these demands to either withhold or to overcompensate. Given the more pliable psychological boundaries of medical and surgical units and the frequent somatic presentation of symptoms, we would anticipate that older BPD patients often end up on these units, where staff may easily fall prey to overhospitalizing and overtreating such patients.

The particular extent to which somatic symptoms induced guilt and helplessness in staff powerfully defined the interpersonal encounters for our patients. Their frantic efforts to defend against feelings of abandonment via somatization appears to represent a different defensive expression than the impulsive symptoms of younger BPD pa-

tients. Perhaps, as their psychological losses and physical needs increase, and as the hope of intrapsychic restitution fades, older BPD patients become more vulnerable to primitive somatic regression than do their more youthful BPD counterparts. Given the nature of BPD pathology, it should not be surprising that older BPD patients shift their defensive efforts in order to have their particular age-related needs and demands met. In this regard, Gabbard (19) and Bonner and Howard (20) suggest that the presence of multiple treaters for BPD patients tends to generate transference-countertransference reactions that are particularly vulnerable to defensive 'splitting', and can result in hesitancy and confusion on the part of professional caretakers to treat older patients in more treatment assertive ways. The authors further suggest that such treatment can become particularly difficult in the presence of somatized clinical conditions.

In order to understand the connection between the observed predominance of regressive somatic symptoms that may be unique in older BPD patients, the inclusion of late-onset symptoms and behaviors would be a valuable addition to DSM criteria. Furthermore, Stone (1) emphasizes the need for investigations that describe the developmental linkages within the BPD patient's 'inner script', in order to understand the degree to which linkages exert powerful influences throughout the lifespan, typically outside the domain of conventional diagnosis.

The extent to which somatic concerns and related long-term institutional dependencies may combine to preoccupy the lives and behaviors of older BPD patients also directly clash with managed-care and cost-containment directives. This particular dilemma will continue to contribute added tensions to inpatient treatment. Confirmation of our preliminary case findings will require further investigations targeting older BPD patients and their professional caretakers within various institutional settings.

ACKNOWLEDGMENTS

We would like to express our gratitude to the interdisciplinary staff and treatment team members of the Inpatient Service, Department of Psychiatry, Health Science Center at Brooklyn for their important contributions, and to Cavin Leeman, M.D. for sharing his insights, knowledge, and wisdom regarding the therapeutic community milieu during his tenure as the Director of Inpatient Services, Department

of Psychiatry, State University of New York, Health Science Center at Brooklyn.

REFERENCES

1. Stone MH: Borderline personality disorder: Course of illness, in *Borderline Personality Disorder: Clinical and Empirical Perspectives*. Edited by Clarkin JF, Marziali E. New York, Guilford Press, 1992.
2. Siegal DJ, Small GW: Borderline personality disorder in the elderly: A case study. *Canadian Journal of Psychiatry* 31: 859–860, 1986.
3. Rosowsky E, Gurian B: Impact of borderline personality disorder in late life on systems of care. *Hospital and Community Psychiatry* 43: 386–389, 1992.
4. Paris J, Brown R, Nowlis D: Long-term follow-up of borderline patients in a general hospital. *Comprehensive Psychiatry* 28: 530–535, 1987.
5. Modestin J: Quality of interpersonal relationships: The most characteristic DSM-III Borderline Personality Disorder criterion. *Comprehensive Psychiatry* 28: 397–402, 1987.
6. Adler G: *Borderline Psychopathology and Its Treatment*. New York, Jason Aronson, 1985.
7. Gunderson JG, Sabo AN: The phenomenological and conceptual interface between borderline personality disorder and PTSD. *American Journal of Psychiatry* 150: 19–25, 1993.
8. Kernberg O: *Borderline Conditions and Pathological Narcissism*. New York, Jason Aronson, 1988.
9. Meissner WW: *Treatment of Patients in the Borderline Spectrum*. New York, Jason Aronson, 1988.
10. Searles HF: *My Work With Borderline Patients*. New York, Jason Aronson, 1986.
11. Zanarini MC, Gunderson JG, Frankenberg FR, et al: Discriminating borderline personality disorder from other Axis II disorders. *American Journal of Psychiatry* 147: 161–167, 1990.
12. Waldinger RJ: Intensive psychodynamic therapy with borderline patients: An overview. *American Journal of Psychiatry* 144: 267–274, 1987.
13. Rose MW, Soares HH, Joseph C: Frail elderly clients with personality disorders: A challenge for social work. *Journal of Gerontological Social Work* 19: 153–165, 1993.
14. Miller BC: Characteristics of effective day treatment programming for persons with borderline personality disorder. *Psychiatric Services* 46: 605–608, 1995.
15. Marcus PE: *Borderline families*, in *Family Psychiatric Nursing*. Edited by Fawcett CS. St. Louis, Mosby, 1993.
16. Paris J, Braverman S: Successful and unsuccessful marriages in borderline patients. *Journal of the American Academy of Psychoanalysis* 23: 153–166, 1995.
17. *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, 4th ed. Washington, DC, American Psychiatric Association, 1994.
18. Gunderson JG: The borderline patient's intolerance of aloneness: Insecure attachments and therapist availability. *American Journal of Psychiatry*: 752–758, 1996.
19. Gabbard GO: Splitting in hospital treatment. *American Journal of Psychiatry*: 444–451, 1989.
20. Bonner D, Howard R: Treatment resistant depression in the elderly. *International Journal of Geriatric Psychiatry* 10: 259–264, 1995.